Washington State Department of CHILDREN, YOUTH & FAMILIES

Foster Parent Reimbursement Claim Checklist

To be Completed by Foster Parent

- ☐ Complete a current Foster Parent Reimbursement Claim form, DCYF 18-400.
  Note: For claims involving individuals who are not licensed foster parents, complete the Foster Parent Liability Claim DCYF 18-400A form.
- ☐ For each item claimed, provide the date of occurrence; state the specific injury/damage/loss item; describe the circumstances of the injury/damage/loss; indicate what supervision was being provided at the time of the incident; the steps taken to reduce the risk of the occurrence; and the steps to be taken to protect against similar future occurrences.
- ☐ For property damage/loss items, indicate the original purchase cost and the date the incident occurred.
- ☐ Provide the full name, home address, and contact telephone numbers for all available witnesses to the injury/damage/loss occurrence.
- ☐ Sign and date the form; send completed form and attachments to the child's caseworker

Property Damage / Loss Items:

- ☐ Property damage: Send a detailed estimate or final repair/cleaning bill signed by retailer to substantiate claim.
  Note: Labor costs are not paid when a foster parent does their own work. We will pay for the cost of materials needed to make the repairs.
- ☐ Property loss and property damage that cannot be repaired or cleaned: Send two replacement estimates by different retailers **or** the replacement purchase receipt for comparable item of similar kind and quality (same model, brand, features, etc.) and a copy of the original purchase receipt if available. Estimates an in store or online retailer
- ☐ Property damages/losses relating to theft, vandalism, and fire: Send a copy of the police or fire department report along with any follow-up investigation findings for claims over $250.00 ($100.00 for money).
- ☐ Photos which show the damage may be required if property damage is not seen by child's caseworker.

Emergency Medical Treatment, Dental. or Vision Expenses:

- ☐ Medical/Dental/Vision: Send copy of provider bill or insurance statement, and for injuries provide the medical discharge notes. Payment is limited to costs that are not covered by insurance.
- ☐ Dental: Comparable replacement of dental appliances paid (if not repairable) up to maximum allowed.
- ☐ Vision: Send the replacement purchase receipt **or** two estimates detailed and signed by different retailers for comparable replacement of eyeglasses/contacts (repair bill if repairable) and a copy of the original purchase receipt if available.

Washington State Department of CHILDREN, YOUTH & FAMILIES

Foster Parent Reimbursement Claim

INTERNAL USE ONLY

☐ Filed by Licensed Foster Parent ☐ Filed by Respite Provider

CLAIM VALUE (TOTAL AMOUNT REQUESTED)

Foster parents must complete this form to request reimbursement for property damages/losses and initial emergency medical treatment expenses incurred because of an act of your foster/respite care child. Claims must be submitted to the child's caseworker within 30 days of an injury, damage, or loss occurrence. **Claims not received DCYF within one year of an occurrence may be denied.**

1. Foster Parent or Respite Provider Information (Print)

NAME	HOME TELEPHONE NUMBER	WORK PHONE NUMBER
	( )	( )

MAILING ADDRESS CITY STATE ZIP CODE

2. Foster Child(ren) who caused damage or loss, or emergency medical expenses

LAST NAME	FIRST NAME	BIRTHDATE	STATUS (CHECK ONE)
			☐ Foster Child ☐ Respite Child
			☐ Foster Child ☐ Respite Child
			☐ Foster Child ☐ Respite Child

3. Substantiating Information: Complete This Section on Separate Form for Additional Items (Print Legibly)

FOR PROPERTY DAMAGE / LOSS ITEMS	ITEM 1	ITEM 2	ITEM 3
a. **Date of occurrence**			
b. **Damage / loss item** (i.e., television)			
c. **Original purchase cost and date originally purchased**			
d. **Repair / cleaning cost** (for damaged items)			
e. **Comparable replacement costs** (For damaged items and items that cannot be repaired. Attach a copy of replacement receipt or retain two estimates.) RECEIPT **OR**			
ESTIMATE 1 **AND**			
ESTIMATE 2			
f. **Amount paid by insurance** ☐ NA ☐ Copy of Statement Attached			
FOR EMERGENCY MEDICAL TREATMENT / DENTAL / VISION EXPENSE CLAIMS	**ITEM 1**	**ITEM 2**	**ITEM 3**
g. **Amount of bill** (attach copy of bill or statement)			
h. **Amount Paid by Insurance** ☐ NA ☐ Copy of Statement Attached			

i. Circumstances: Describe **HOW** and **WHAT** specific injury, damage, or loss occurred. If needed, attach a separate sheet to continue your description statement.

j. Describe what supervision was being provided at the time the injury/damage/loss occurred and what steps had been taken to reduce the risk of the occurrence. Indicate what steps will be taken to protect against similar future occurrences.

4. Substantiating Documentation

Attach the required substantiating documents for all items claimed as stated on the claim checklist. Picture(s) of the damage may be required. A copy of the police or fire department report along with any follow-up investigation findings must be attached for claims over $250.00 relating to theft, vandalism, and fire ($100.00 for money). Reimbursement will not be made without all the required documents and information.

5. Witness(es) to the Injury / Damage / Loss Occurrence (Print)

NAME	HOME TELEPHONE NUMBER ( )	WORK TELEPHONE NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP CODE
NAME	HOME PHONE NUMBER ( )	WORK PHONE NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP CODE

6. Claim Validation

SIGNATURE	DATE

TO BE COMPLETED BY CHILD'S CASEWORKER

☐ Reviewed claim for accuracy, completeness, timeliness, support documents, and signature.

Please Note:

- Failure to provide all the required information will cause a delay in reimbursement to the foster parent.
- For claims submitted more than 90 days after an occurrence, include a statement with the reason for the delay in filing the claim. Claims not received by DCYF within one year of an occurrence may be denied.

1. CHILDREN'S FIRST NAME AND CASE NUMBER(S)		2. PLACEMENT INFORMATION	
		to	☐ Still in Home
		to	☐ Still in Home
		to	☐ Still in Home

3. State the reasons why you do or do not concur. Provide any other pertinent information (attach additional pages if necessary).

NAME OF CASEWORKER (PRINT)	FIELD OFFICE	REGION	MAIL STOP
CASEWORKER (SIGNATURE)	DATE	TELEPHONE NUMBER ( )	